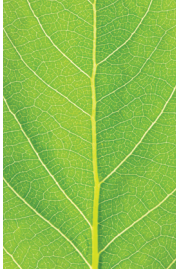
PCL ALVERNO


TEST BULLETIN

February 2015

Dear Healthcare Provider,

The information contained in this packet may be very important to your practice. Below is a quick summary of the items that are included in this mailing. Please take a moment to read this and review the enclosed material for detailed information.

NEW TEST COMING IN FEBRUARY

- Identification of Mycoplasma pneumonia by culture is both time consuming and difficult on routine media. Real-time PCR offers a rapid and sensitive option for the detection of M. pneumonia from clinical specimens. Beginning February 15, 2015, PCL Alverno will offer testing of this bacterium by PCR methodology, offering you improved turnaround times compared to identification by culture. See page 4 for further information.

TEST UPDATE

- ANA – Anti-nuclear antibody test reporting has been changed to include a remark that reads: “If the patient exhibits clinical signs and symptoms suggestive of a rheumatologic disorder and the Bioplex test is negative, repeat testing using an alternative method (IFA) is recommended.” See page 2 for full details.

“DIAGNOSING DIABETES” – BY ELLEN POLISKY, M.D.

- Dr. Polisky is a respected pathologist and has been a member of the Medical staff at Presence Saints Mary and Elizabeth Medical Center since 1987. Earning her medical degree at the Chicago Medical School, Dr. Polisky completed her pathology residency and served for a time as the Chief Resident at the University of Illinois Hospital/WSVA in Chicago. She is certified by the American Board of Pathology in anatomic and clinical pathology. Please find her article related to diabetes diagnostic testing on page 3.

VISIT OUR WEBSITE TO SIGN UP FOR OUR BLOG

- Please be sure to sign up for our blog so that you will continue to receive our test update bulletins. Our last update will be mailed in June of 2015. Beginning in July, clinical information will only be shared by subscribing to the blog and receiving email updates. Only clinical information will be shared, so you don’t have to worry about receiving advertising or other unnecessary emails from us. Check it out at http://www.pclalverno.com/providers/test-information-changes/alverno-news.

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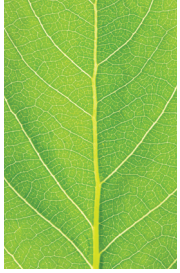


Test Summary
Utilization Guidelines

ANTI-NUCLEAR ANTIBODY
Test Change Notification

CLINICAL USE
The anti-nuclear antibody test or ANA is used in the diagnosis of rheumatological disorders.

TEST CHANGES
In January, PCL Alverno discontinued the ANA Screen without reflex testing. This decision was made in concordance with best patient care. A positive ANA screening alone provides limited usefulness and follow-up testing is necessary for accurate diagnosis. In most cases this would be done by a consultant rheumatologist.

A complete ANA panel presented on referral will aid in the follow-up care to the patient. Without this information, the referred physician would need to order the ANA screen with reflex, resulting in duplicate testing and delay of care.

REPORTING UPDATE
Negative screen results now have a comment to address clinically symptomatic patients that screen test negative.

Antinuclear Antibodies **see below**

NEGATIVE

All antibody levels for systemic autoimmune disease are below pre established cutoffs for the following analytes: dsDNA, Chromatin, Ribosomal P, SS/A, SS/B, Sm, SmRNP, RNP, Scl 70, Jo 1 and Centromere B. A negative result does not rule out autoimmune disease.

If the patient exhibits clinical signs and symptoms suggestive of a rheumatologic disorder and the Bioplex test is negative, repeat testing using an alternative method (IFA) is recommended.

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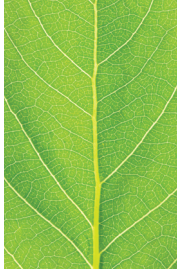



DIAGNOSING DIABETES

Ellen Polisky, M.D.

Diabetes is one of the major causes of early illness and death worldwide. Type 2 diabetes accounts for over 90% of these patients and approximately 14% of U.S. healthcare expenditures, at least one-half of which are related to vascular complications like MI, stroke, end-stage renal disease, retinopathy, and foot ulcers. In addition to the obvious impact on quality of life and economics, there are also adverse effects on employment, absenteeism, and work productivity. The following addresses recommendations regarding the screening of individuals (including pregnant women) for type 2 diabetes.

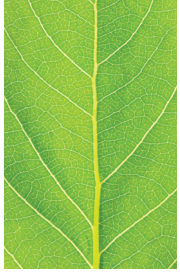
For the general population, the most common tests used to screen for type 2 diabetes are fasting plasma glucose, glycolated hemoglobin (A1C), and the two-hour oral glucose tolerance test, the latter of which has become somewhat less popular of late. When both fasting glucose (<100 mg/dl) and A1C (<5.7%) are within normal range, follow-up testing is recommended every three years. With borderline elevated results (fasting glucose 100-125 mg/dl and A1C 5.7 - 6.4 mmol/l), annual testing is recommended. Diabetes is confirmed with two elevated A1C levels (>6.5%) and/or two consecutive fasting glucose levels (>126 mg/dl).

In pregnant women with high risk factor, screening is performed at the first prenatal visit. In the absence of early screening, universal screening is recommended after 24 weeks. The testing has been categorized as a one- or two-step approach.

- The one-step approach omits screening (with 50 gram oral glucose challenge test) and proceeds with a 75 gram, two hour GTT.
- The two-step approach (actually most widely used in the U.S. and supported by ACOG and the ADA) involves a glucose challenge test of a 50 gram oral glucose load without regard to time elapsed since the last meal, and the glucose level is measured one hour later. If >140 mg/dl, an oral glucose tolerance test is ordered. For this, the patient must be fasting (other than a few water sips) for 8-14 hours. Blood will be drawn before drinking a 100 gram glucose solution, then again every hour after drinking it, up to three hours total. Abnormal results would be a fasting level >95 mg/dl; one hour >180 mg/dl; two hour >155 mg/dl, and three hour >140 mg/dl. Two elevated blood results would be indicative of gestational diabetes.

References:

American Diabetes Association. Standards of medical care in diabetes; Diabetes Care 2013;36 Supp 1:S11.
Cowie CC, et al. Full accounting of diabetes and pre-diabetes in the US population in 2005-2006; Diabetes Care 2009;32:287.
CDC. National Diabetes Fact Sheet, 2007. http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2007.pdf.
Donovan,L, et al. Screening test for gestational diabetes; a systematic review for the US Preventive Services Task Force. Ann Intern Med 2013;159:115.


MYCOPLASMA PNEUMONIAE DETECTION BY PCR

February 15, 2015

CLINICAL USE

Used for the diagnosis of infections due to Mycoplasma pneumonia.

CLINICAL BACKGROUND

Mycoplasma pneumonia is small bacterium that can cause upper respiratory infection, pharyngitis, and tracheobronchitis, particularly in children. Approximately 20% of cases of community-acquired pneumonia have been associated with M. pneumoniae. The disease is usually self-limited although severe complications such as central nervous system and cardiac manifestations have been reported in immunocompromised patients.

Identification of Mycoplasma pneumonia by culture is both time consuming and difficult on routine media. Real-time PCR offers a rapid and sensitive option for the detection of M. pneumonia from clinical specimens.

SPECIMEN REQUIREMENTS

Specimen: 3 mL Nasopharyngeal or throat swabs in M4 or VCM Transport Medium.
1 mL Bronchial washings in a sterile plastic, leak-proof container.
Stability: Room temperature: 48 hours; Refrigerated: 7 days; Frozen: 30 days

CAUSE FOR REJECTION

Improper transport media or container leakage.

METHOD

Real-Time Polymerase Chain Reaction (PCR)

REFERENCE RANGE

Negative

TURNAROUND TIME

Testing is batched on Monday, Wednesday and Friday

CPT CODE*

87581

*CPT codes provided are for informational purposes only. Questions regarding coding should be directed to the payer.